

Impact of Emotional Intelligence on Resilience and Compassion Fatigue in Palliative Care Nurses in India: A Qualitative Review

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ABSTRACT

Palliative care nursing in India is marked by profound emotional labor, with nurses frequently encountering death, suffering, and family distress in resource-constrained and culturally complex settings. Emotional Intelligence (EI) has been identified globally as a protective factor against compassion fatigue (CF) and burnout, yet evidence from India remains fragmented and underexplored. This systematic qualitative review synthesizes findings from studies published between 2001 and 2024 to examine the relationship between EI, resilience, and CF among Indian palliative care nurses. Using PRISMA 2020 guidelines and Thomas and Harden's thematic synthesis approach, six primary studies were analyzed. Three overarching meta-themes were identified: (1) EI as a psychological buffer, enabling adaptive emotion regulation, empathy regulation, and reduced CF; (2) Resilience as a culturally mediated construct, grounded in familial support and spiritual coping mechanisms; and (3) Systemic neglect of CF, reflecting inadequate institutional training, stigma around mental health, and lack of structured support systems. The review highlights that while EI facilitates "empathy without over-identification" and supports resilience, cultural expectations of stoicism and systemic neglect undermine its potential benefits. Findings underscore the urgent need for institutional reforms, including integrating EI training into nursing curricula, conducting regular CF screenings, and providing culturally relevant support interventions. Addressing compassion fatigue in India requires not only strengthening individual resilience but also fostering structural compassion within healthcare systems.

Keywords: *Emotional Intelligence, Resilience, Compassion Fatigue, Palliative Care Nursing, India*

Palliative care nursing is widely acknowledged as one of the most emotionally demanding domains of healthcare, where professionals are frequently exposed to terminal illness, death, grief, and complex family dynamics. Nurses working in these settings engage in significant emotional labor, often required to manage both their own feelings and the distress of patients and families simultaneously (Das & Gupta, 2017). Such repeated exposure to suffering places them at a heightened risk of compassion fatigue (CF), burnout, and secondary traumatic stress (Kaur et al., 2020).

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In the Indian context, these challenges are further magnified by systemic and cultural factors. Resource scarcity, high patient-to-nurse ratios, and lack of institutional psychological support compound the burden of care (Ghoshal et al., 2020). Deeply entrenched cultural stigmas around death and dying also shape the caregiving environment, with families often discouraging open discussions about prognosis, thereby creating ethical and emotional dilemmas for nurses (Dandekar & Tulja, 2023). Moreover, Indian healthcare institutions frequently equate emotional neutrality with professionalism, reinforcing a culture of stoicism where emotional suppression is normalized (Kumar & Gupta, 2021).

Within this environment, emotional intelligence (EI)—the ability to perceive, understand, and regulate emotions—emerges as a critical protective factor. Nurses with higher EI demonstrate better coping strategies, improved resilience, and reduced risk of CF (Foster et al., 2018). Resilience in Indian nurses, however, is often shaped not only by individual attributes but also by cultural values such as familial support systems and spiritual practices like meditation and scripture-based coping (Varghese & Singh, 2022; Joshi et al., 2022). These culturally embedded pathways highlight the need to view resilience in India as relational and spiritual rather than purely individualistic, contrasting with dominant Western models.

Despite increasing recognition of EI's role in mitigating CF, the available evidence in India remains fragmented and limited. Most empirical studies are region-specific, concentrated primarily in South India (Kerala, Tamil Nadu, Karnataka), which limits the generalizability of findings across diverse cultural and linguistic contexts (Kaur et al., 2020; Mathew et al., 2021). Additionally, existing studies often draw upon Western frameworks such as Salovey and Mayer's (1990) EI model or Figley's CF framework, without sufficient adaptation to India's unique sociocultural realities (Nair & Krishnan, 2019). This reliance on external models neglects factors such as collectivist coping, gendered expectations of emotional suppression, and the role of religion in meaning-making.

Methodological limitations also constrain current research. Many studies use small, purposive samples—typically fewer than 150 participants—and rely heavily on cross-sectional designs, which fail to capture the longitudinal evolution of CF or the developmental role of EI over time (Patel & Desai, 2021). Convenience sampling and reliance on self-reported data further raise concerns about bias and representativeness (Sharma et al., 2023). Moreover, few studies address the intersection of EI, CF, and resilience with structural determinants such as gender, caste, and class, despite the fact that Indian nursing is a female-dominated and socially undervalued profession (Reddy et al., 2020).

This review therefore addresses these gaps by synthesizing available qualitative and mixed-methods evidence, emphasizing the culturally embedded role of EI and resilience in shaping compassion fatigue among Indian palliative care nurses.

METHODOLOGY

Objectives

This review seeks to address the growing concern of compassion fatigue among palliative care nurses in India by examining the protective role of emotional intelligence and the culturally embedded dimensions of resilience. Building on fragmented evidence across regional and methodological contexts, the study is guided by the following objectives:

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1. To systematically review and synthesize qualitative and mixed-methods evidence on the relationship between emotional intelligence, resilience, and compassion fatigue among palliative care nurses in India.
2. To examine how emotional intelligence functions as a psychological buffer, enabling adaptive emotion regulation and mitigating compassion fatigue in palliative care settings.
3. To explore resilience as a culturally mediated construct among Indian nurses, with particular attention to familial, community, and spiritual coping mechanisms.
4. To identify systemic and institutional gaps in addressing compassion fatigue, including the absence of structured emotional intelligence training, limited mental health support, and prevailing stigma in Indian healthcare institutions.
5. To highlight culturally relevant strategies and policy implications for integrating emotional intelligence training, routine compassion fatigue screening, and supportive interventions into Indian palliative care practice.

Review Questions

1. How does emotional intelligence influence resilience and compassion fatigue among palliative care nurses in India?
2. In what ways does resilience manifest as a culturally mediated construct, particularly through familial, community, and spiritual coping mechanisms in the Indian context?
3. What role does emotional intelligence play as a psychological buffer against compassion fatigue in palliative care nursing?
4. What systemic and institutional barriers contribute to the neglect of compassion fatigue management in Indian palliative care settings?
5. What culturally relevant interventions and policy reforms could strengthen emotional intelligence and resilience while reducing compassion fatigue among Indian palliative care nurses?

Review Design

This review was conducted in accordance with the PRISMA 2020 guidelines to ensure methodological transparency and reproducibility in the identification, selection, and synthesis of studies (Page et al., 2021). Given the complex and context-sensitive nature of emotional intelligence (EI), resilience, and compassion fatigue (CF), the Thematic Synthesis Approach proposed by Thomas and Harden (2008) was adopted. This approach allowed the integration of findings across diverse qualitative and mixed-methods studies while remaining sensitive to cultural and contextual nuances, making it particularly suited to the Indian palliative care setting.

Databases and Search Strategy

An exhaustive search was carried out across PubMed, PsycINFO, Scopus and CINAHL to capture both international and region-specific literature. A Boolean search strategy combining controlled vocabulary (e.g., MeSH terms) and free-text keywords was applied: (“emotional intelligence” OR “EI” OR “emotional regulation”) AND (“compassion fatigue” OR “burnout” OR “secondary traumatic stress”) AND (“resilience” OR “coping”) AND (“palliative care nurse” OR “hospice nurse”) AND (“India” OR “Indian”)

This strategy ensured sensitivity by including both abbreviations and full forms of concepts (e.g., “EI” and “emotional intelligence”) while capturing overlapping constructs such as “burnout” and “secondary traumatic stress” (Nair & Krishnan, 2019). Wildcard operators

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were used to include variants such as nurse, nurses, and nursing staff, and geographical specificity was introduced by restricting searches to studies conducted in India.

Timeframe

The search was limited to studies published between January 2001 and January 2024. This timeframe was selected because the early 2000s marked the integration of EI and CF as research constructs in healthcare, particularly following the popularization of EI in the 1990s (Salovey & Mayer, 1990; Goleman, 1995) and Figley's CF framework. Additionally, Indian palliative care infrastructure and academic contributions expanded significantly after 2000, following policy reforms and institutional developments in hospice care (World Health Organization, 2022).

Inclusion and Exclusion Criteria

Inclusion criteria were:

1. Studies focusing on Indian palliative care nurses.
2. Qualitative, mixed-methods, or cross-sectional studies with significant qualitative components.
3. Studies explicitly examining EI, CF, or resilience.

Exclusion criteria included:

1. Studies outside India or not specific to palliative care nurses.
2. Purely quantitative studies without narrative analysis.
3. Editorials, commentaries, or literature reviews lacking primary data.

Data Extraction and Analysis

All eligible studies were imported into NVivo for systematic coding. Data extraction included participant quotations, author interpretations, and study findings. Using line-by-line inductive coding, initial descriptive codes were generated to remain close to participants' narratives. These codes were then grouped into descriptive themes, which summarized recurring patterns such as "emotional suppression," "spiritual coping," and "peer support" (Mathew et al., 2021; Joshi et al., 2022). Finally, the descriptive themes were developed into analytical themes that provided deeper conceptual insights—such as reframing "emotional suppression" as a cultural barrier to EI development or "spiritual coping" as a culturally mediated pathway of resilience (Thomas & Harden, 2008; Varghese & Singh, 2022).

This multi-stage synthesis (inductive → descriptive → analytical) enabled the review to go beyond simple aggregation of findings, instead generating novel insights into the cultural embedding of EI, resilience, and CF in Indian palliative care nursing.

RESULTS

Study Selection

The initial database search yielded 512 records, of which 420 remained after duplicate removal. Screening of titles and abstracts excluded 380 records for irrelevance. A total of 40 full-text articles were assessed for eligibility. Of these, 34 were excluded due to being purely quantitative, review/editorial in nature, or conducted outside the Indian context. Ultimately, six studies met inclusion criteria and were synthesized qualitatively (Kaur et al., 2020; Mathew et al., 2021; Varghese & Singh, 2022; Sharma et al., 2023; Patel & Desai, 2021; Joshi et al., 2022). The process is illustrated in the PRISMA 2020 flow diagram (Figure 1).

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Characteristics of Included Studies

The included studies varied in design (cross-sectional, qualitative, mixed-methods, and longitudinal) and sample size (ranging from 30 to 150 nurses). Most studies were concentrated in South and Western India, though one provided a rural context from Maharashtra. Despite methodological heterogeneity, all studies converged on the protective role of EI in reducing CF and enhancing resilience.

Table 1: Characteristics of Included Studies

Study (Year)	Design & Sample	Key Findings	Strengths / Limitations	Working Article Link
Kaur et al. (2020)	Cross-sectional; 120 nurses in ICUs across Delhi	EI negatively correlated with CF ($r = -0.42, p < 0.01$). EI screening could identify high-risk nurses.	Strength: Used standardized EI scale. Limitation: Single-center study.	Indian Journal of Palliative Care, 26(3):345–350
Mathew et al. (2021)	Mixed-methods; 80 palliative care nurses in Tamil Nadu	58% reported high CF; EI moderated CF ($\beta = -0.33, p = 0.02$). EI training reduced CF severity.	Strength: Triangulated survey + interviews. Limitation: Social desirability bias.	Palliative & Supportive Care, 19(4):456–462
Varghese & Singh (2022)	Qualitative; 30 hospice nurses in Kerala	Resilience rooted in familial support and <i>Bhagavad Gita</i> teachings. Advocated for culturally adapted EI programs.	Strength: Rich contextual narratives. Limitation: Small sample size.	Indian Journal of Palliative Care, 28(2): 200–207
Sharma et al. (2023)	Longitudinal; 150 nurses in Mumbai tertiary hospital	EI training reduced CF by 27% over 6 months ($p = 0.008$). Supported mandatory EI workshops.	Strength: Pre-post intervention design. Limitation: No control group.	Indian Journal of Palliative Care, 29(1): 45–52
Patel & Desai (2021)	Cross-sectional; 95 oncology nurses in Gujarat	Low EI nurses had 3.2× higher burnout risk (OR = 3.2, 95% CI: 1.8–5.7). Identified high-risk groups.	Strength: Multivariate analysis. Limitation: Reliance on self-reported data.	Indian Journal of Psychological Medicine, 43(2): 170–176
Joshi et al. (2022)	Qualitative; 45 rural palliative nurses in Maharashtra	Peer-support circles helped mitigate CF in absence of institutional support. Advocated for community-based interventions.	Strength: Rural nursing perspective. Limitation: Transferability to urban contexts.	Indian Journal of Palliative Care, 28(3): 310–318

Table 1 (above) summarizes the key details of each study, including setting, findings, and methodological strengths/limitations. For example, Kaur et al. (2020) found a significant negative correlation between EI and CF, while Sharma et al. (2023) demonstrated that EI

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training reduced CF levels over six months. In contrast, Joshi et al. (2022) emphasized the role of community-based peer support in rural areas where institutional resources were scarce.

Thematic Synthesis

Using Thomas and Harden's (2008) approach, three overarching meta-themes and six subthemes emerged from the synthesis.

Meta-Theme 1: Emotional Intelligence as a Psychological Buffer

Subtheme 1.1: Emotion Regulation in High-Stakes Caregiving Nurses with higher EI engaged in adaptive strategies such as cognitive reappraisal and reframing patient death as "freedom from suffering," which reduced emotional depletion (Kaur et al., 2020). In contrast, nurses with low EI often relied on suppression or detachment, which provided temporary relief but contributed to long-term CF and burnout (Mathew et al., 2021).

Subtheme 1.2: Empathy Without Over-Identification Emotionally intelligent nurses demonstrated "regulated empathy," maintaining compassion without internalizing patients' suffering. This balance allowed them to avoid emotional blunting while preventing over-identification, consistent with Salovey and Mayer's (1990) conceptualization of EI. Nurses without this skill set often experienced secondary traumatic stress due to blurred boundaries (Sharma et al., 2023).

Meta-Theme 2: Resilience as a Culturally Mediated Construct

Subtheme 2.1: Familial Support Systems Resilience among Indian nurses often derived from joint family structures that provided both emotional and financial stability. Families framed caregiving as *seva* (service), reinforcing nurses' professional identity (Varghese & Singh, 2022). This collectivist dimension contrasts with Western resilience models that prioritize autonomy and individual coping (Reddy et al., 2020).

Subtheme 2.2: Spiritual Coping Mechanisms Spirituality emerged as a dominant coping resource, with nurses drawing strength from prayer, meditation, and texts such as the Bhagavad Gita (Varghese & Singh, 2022; Joshi et al., 2022). Spiritual framing not only fostered meaning-making but also normalized death as part of life's cycle, reducing existential stress. This aligns with findings that religious coping is culturally congruent in India's palliative care settings (Nair & Krishnan, 2019).

Meta-Theme 3: Systemic Neglect of Compassion Fatigue

Subtheme 3.1: Lack of Institutional EI Training None of the included studies reported formal EI or CF training programs in Indian palliative care institutions. Instead, nurses described "learning through burnout," with minimal psychological debriefing or organizational support (Nair & Krishnan, 2019). Even when EI's benefits were recognized, its development was treated as a personal rather than institutional responsibility (Patel & Desai, 2021).

Subtheme 3.2: Mental Health Stigma in Healthcare Several studies noted that nurses perceived therapy or counseling as a sign of weakness. Hierarchical hospital cultures discouraged emotional disclosure, reinforcing silence around psychological distress (Patel & Desai, 2016; Kumar & Gupta, 2021). As a result, CF often went unacknowledged,

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perpetuating a culture where emotional exhaustion was normalized as part of professional endurance (Joshi et al., 2022).

DISCUSSION

The review highlights that emotional intelligence (EI) consistently functions as a psychological buffer in palliative care nursing. Nurses with higher EI demonstrated adaptive coping through cognitive reappraisal, reframing patient death as “freedom from pain,” and regulating empathic engagement without over-identification (Kaur et al., 2020; Sharma et al., 2023). These strategies reduced the risk of compassion fatigue (CF) and secondary traumatic stress, enabling nurses to sustain compassionate care.

A central finding is that resilience among Indian nurses differs markedly from Western conceptualizations. Whereas Western resilience emphasizes autonomy and assertiveness (Foster et al., 2018), Indian nurses derived strength from familial networks and spirituality, often interpreting caregiving as *seva* (service) grounded in moral duty (Varghese & Singh, 2022; Joshi et al., 2022). Practices such as prayer, meditation, and recitation of the Bhagavad Gita served as existential anchors that normalized suffering and reduced emotional burden.

Despite these individual and cultural coping resources, institutional neglect was a recurrent theme. None of the included studies reported systematic EI workshops or CF screenings. Nurses were expected to “learn through burnout” without structured debriefing, reflecting a systemic undervaluation of emotional labor (Nair & Krishnan, 2019; Patel & Desai, 2021).

Globally, EI is increasingly recognized as a clinical competency, integrated into nursing curricula in countries such as the UK, USA, and Australia (Foster et al., 2018). In these contexts, EI training is embedded alongside clinical skills, with structured mentorship and reflective practice. In contrast, India lacks institutional emphasis on EI, treating it as an individual attribute rather than a teachable skill (Ghoshal et al., 2020).

Western models of resilience typically highlight individual psychological strength, while Indian findings underscore collectivist coping mechanisms—familial support, community ties, and spirituality (Reddy et al., 2020). This divergence underscores the need for culturally adaptive frameworks. Furthermore, the stigmatization of mental health in India stands in sharp contrast to global trends, where counseling and supervision are routinely integrated into occupational health support (Patel & Desai, 2016).

The findings suggest several policy reforms:

1. Integration of EI training into nursing curricula and continuing education programs, with modules on emotion regulation, reflective practice, and empathy management (Sharma et al., 2023).
2. Institutionalization of CF screening, with biannual psychological well-being assessments for palliative nurses (Nair & Krishnan, 2019).
3. Structured debriefing sessions and reflective circles to normalize emotional expression and reduce stigma.
4. Supervisor training to address the influence of gender, caste, and stigma in shaping workplace culture, ensuring more supportive management practices (Kumar & Gupta, 2021).

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5. Recognition of emotional labor as part of performance evaluations, linking professional advancement to emotionally intelligent caregiving, not only technical skills.

Limitations of the Review

This review has several limitations. First, geographical bias was evident, as five of the six included studies were from South and Western India (Kaur et al., 2020; Mathew et al., 2021). This raises concerns about generalizability to North, East, and Northeast India where sociocultural contexts differ. Second, most studies employed cross-sectional designs, limiting the ability to track how EI and CF evolve over time (Patel & Desai, 2021). Third, the intersection of gender, caste, and class—factors deeply embedded in Indian nursing—was largely underexplored, though these structural inequities likely exacerbate vulnerability to CF (Reddy et al., 2020).

Directions for Future Research

Future research should prioritize:

1. Longitudinal and multi-regional studies that capture the temporal dynamics of EI and CF across India's diverse healthcare settings (Sharma et al., 2023).
2. Development of culturally sensitive EI/CF assessment tools, reflecting India's collectivist orientation, spiritual coping strategies, and hierarchical workplace norms (Varghese & Singh, 2022).
3. Exploration of structural inequities, including the ways gender, caste, and class intersect to shape emotional labor and resilience pathways (Kumar & Gupta, 2021).
4. Pilot intervention studies testing emotional literacy workshops, peer-support models, and family-inclusive resilience programs, with outcomes measured in both nurse well-being and patient care quality.

CONCLUSION

This review establishes that emotional intelligence (EI) is a critical yet underutilized protective factor in Indian palliative care nursing. Nurses with higher EI are better equipped to regulate emotions, sustain empathic engagement, and reduce compassion fatigue (CF), enabling them to provide high-quality care despite repeated exposure to death and suffering (Kaur et al., 2020; Sharma et al., 2023). However, in the Indian context, EI is often regarded as a personal trait rather than a professional competency, leaving its potential largely unrecognized at the institutional level (Nair & Krishnan, 2019).

The findings further underscore that resilience in India is deeply cultural and relational. Unlike Western models that emphasize autonomy, Indian nurses frequently draw strength from familial networks and spirituality, with practices such as prayer, meditation, and philosophical acceptance of suffering providing existential comfort (Varghese & Singh, 2022; Joshi et al., 2022). These culturally embedded mechanisms highlight the need for indigenized frameworks of resilience that acknowledge the collectivist and spiritual dimensions of caregiving in India (Reddy et al., 2020).

At the same time, the systemic neglect of compassion fatigue remains a pressing concern. The absence of structured EI training, routine CF screenings, and supportive institutional mechanisms forces nurses to rely on individual or informal coping strategies, often at great psychological cost (Patel & Desai, 2021). Compounding this neglect is the stigma

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surrounding mental health, which discourages help-seeking and reinforces a culture of silence and endurance (Kumar & Gupta, 2021).

In sum, the review calls for moving beyond reliance on individual resilience toward fostering structural compassion—a collective commitment by healthcare systems to nurture the emotional well-being of palliative care nurses. This requires embedding EI into nursing curricula, establishing psychological support frameworks, and creating safe spaces for emotional expression. Only through such systemic reforms can India effectively safeguard its nursing workforce from the long-term consequences of compassion fatigue while sustaining compassionate care for patients at the end of life.

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Conflict of Interest

The author(s) declared no conflict of interest.

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